

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) HCP    ( ) IE    ( ) IC Requestor's Name and Address Edward Wolski, M.D. / Wol+Med 2436 I-35 South, Ste. 336 Denton TX 75205	<b>Response Timely Filed?</b> ( ) Yes    ( ) No MDR Tracking No.: M4-03-8738-01 TWCC No.: Injured Employee's Name: Date of Injury: Employer's Name: BELO Corp. Insurance Carrier's No.: 4650159126
Respondent's Name and Address      BOX #: 39 Lumbermens Mutual Casualty Co. / Kemper Serv. PO Box 749010 Dallas TX 75374-9010	

## PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
8/1/02	9/23/02	97024, 97110, 97530, 95851, 99213	\$329.00	\$0.00

## PART III: REQUESTOR'S POSITION SUMMARY

7/29/03: "...Our position regarding the denials are as follows: 1) All service dates reported – The carrier failed to respond in any way to our initial billing, and or request for reconsideration. We provided confirmation of the carrier's receipt of the billings...The carrier has failed to respond..."

## PART IV: RESPONDENT'S POSITION SUMMARY

8/1/03 and 8/18/03: "In response...For DOS 8/1/02 and 8/9/02 we answered that further physical therapy was deemed unnecessary per 6/18/02 peer review. The *original audit* date was 10/23/02 for DOS 8/1/02 which was received on 9/16/02 (by carrier). This EOB was sent along with a copy of the peer review to the provider. Also the original audit date was 10/23/02 for DOS 8/9/02, also received on 9/16/02. This EOB was also sent to provider along with copy of the peer review. There was never a response from the doctor...Also, please find where reconsideration EOB's were sent out on both dates of service.

For DOS 8/29/02, the bill was never received, but has been paid. (Attached documentation.)

For DOS 9/23/02 it had been received, but audited incorrectly. The bill has been (since been re audited and now) paid. (Attached documentation.)...Carrier has paid...and the provider has not submitted any additional documentation regarding the (DOS) 8/1/02 and 8/9/02..."

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- On 7/18/03, MDR received the Requestor's request for reimbursement of treatment/services rendered from DOS 8/1 /02 through 9/23/03.
- To make the dispute complete, the Respondent provided copies of EOB's according to Rule 133.307 (e)(2)(B) for the DOS in dispute.
- The Requestor did not respond (per telephone message left on Requestor's recorder,) to a current status request, as case appeared to have been paid.
- Respondent did respond to the Requestors reconsideration requests as the Requestor attached the TWCC-62 dated 5/23/03 to the MDR request.

- After review of the combination of information received from the Requestor and Respondent, the following conclusions have been determined:
  - 1) Respondent did reimburse the Requestor per applicable guidelines according to the EOB's submitted. The Requestor provided convincing evidence that the HCFA's were submitted for reimbursement and reconsideration to the Respondent according to 133.304(k).
  - 2) DOS: 8/1/02 and 8/9/02: CPT codes were denied with "F."  
The Respondent provided convincing evidence that the HCFA's were audited and paid according the 1996 MFG. The audit date of 10/23/02 shows the following CPT codes paid: 97024 paid \$21.00; 97110 paid \$35.00; 97530 paid \$35.00; and audit date of 6/17/03 shows 95851 paid \$72.00.  
No medical documentation was submitted for review for these DOS to support any additional reimbursement. Therefore no additional reimbursement can be recommended.
  - 3) DOS 8/29/02 and 9/23/02 for CPT code 99213 were audited and reimbursed/ "F"- according to MFG /MAR in the amount of \$48.00 for each DOS.
  - 4) Therefore, due to no response from the Requester for a current status via telephone message, and to correct reimbursement indicated on the EOB's, no additional reimbursement recommended.

#### PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

6 / 27 / 05

Authorized Signature

Name

Date of Order

#### PART V: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, PO Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

#### PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_